



County of Los Angeles CHIEF EXECUTIVE OFFICE

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WILLIAM T FUJIOKA
Chief Executive Officer

March 31, 2011

To: Mayor Michael D. Antonovich
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

From: William T Fujioka
Chief Executive Officer

Board of Supervisors
GLORIA MOLINA
First District

MARK RIDLEY-THOMAS
Second District

ZEV YAROSLAVSKY
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

RESPONSE TO REPORTING AGGREGATE AND TREND DATA ON CHILD DEATHS BOARD MOTION (ITEM NO. 48-B, AGENDA OF OCTOBER 12, 2010)

On October 12, 2010, and further amended on November 3, 2010, by motion of Supervisors Mark Ridley-Thomas and Mayor Michael D. Antonovich, your Board directed the Chief Executive Officer (CEO), in consultation with the Department of Children and Family Services (DCFS) and County Counsel, to compile vital Los Angeles County child death statistics for the past ten years including, but not limited to: 1) the total number of deaths of children with prior DCFS history; 2) age, area of residence and area of death location of the child; 3) cause of death and circumstances; 4) abuse or neglect status; 5) alleged perpetrator in homicides; 6) DCFS status and placement at time of death; 7) race/ethnicity of the child; and 8) indication of whether one or both parents were minors at the time of the child's birth. In addition, your Board directed the CEO to report back with a plan to designate a single County entity to be responsible for consistently tracking and compiling Los Angeles County data on child abuse, neglect, and deaths.

I. Reporting Aggregate and Trend Data on Child Deaths

A work group consisting of CEO, DCFS, and County Counsel members convened in October 2010 and met on a regular basis to review and analyze available aggregate data on child fatalities with DCFS history. The intent was to gather data on all modes of child fatalities – including for example, natural deaths, accidental deaths, third-party homicides, and suicides. It was determined that the state's Child Welfare Services/Case Management System (CWS/CMS) was the appropriate data

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source to compile aggregate child fatality data going back to Calendar Year (CY) 2000.

It is important to note that CWS/CMS does not track all of the requested data elements required in the Board motion. For example, CWS/CMS does not track mode-of-death per the Coroner or location of the incident that led to the child's death. To the extent that CWS/CMS tracks fatality data, not all data fields are mandatory which may result in the imperfect capture of data. In addition, over the years reporting requirements have changed whereby the Coroner started to report all child homicides, rather than just homicides believed to be caused by abuse and/or neglect by a parent or caregiver. This change resulted in an increase in the total number of child deaths reported, starting in CY 2005. To that end, aggregate data from CWS/CMS is difficult to validate going back to CY 2000, and may not present comprehensive information on child fatalities that can be used to analyze child fatality trends and patterns.

To present more current and comprehensive information on child fatalities, additional analysis and validation was conducted to report on data elements that are not tracked within CWS/CMS for CY 2010 only. These additional data elements include: 1) Fatalities with a reasonable suspicion or a determination that abuse/neglect led to the child's death (Senate Bill 39); 2) incident location; and 3) final mode-of-death per the Coroner. For comparative purposes we have also provided data on children with an open DCFS case in CY 2010 and general population statistics on children living in LA County.

The Board motion calls for child fatality statistics for children with DCFS history. The following chart depicts the parameters by which DCFS history was defined for the purposes of this report:

Category	Parameters
Child	Child has an open case or referral at the time of death or a closed case or referral prior to the date of death (at any point in his/her lifetime)
Sibling	Sibling of the deceased child has an open case or referral at the time of death or a closed case or referral prior to the child's date of death (at any point in the sibling's lifetime – even if it occurs prior to the deceased child's date of birth)
Parent	Parent of the deceased child has a closed case or referral prior to the child's date of death in which they are the alleged perpetrator (at any point in the parent's lifetime – even if it occurs prior to the deceased child's date of birth)

All graphs and charts on available data elements are presented in Attachment A.

Issues with Existing Child Fatality Data

Efforts were made to compile child fatality data that CWS/CMS does not systematically track; however, it is evident from reviewing the available data that a standardized process for compiling and reporting pertinent child fatality data needs to be developed. For example, there is no systematic data available on child fatality trends and circumstances. Clear, concise data on child fatality trends, such as gang-related shootings and co-sleeping deaths, will allow for more informed policy discussions related to child welfare. In addition, there are a multitude of entities (e.g., Inter-Agency Council on Child Abuse and Neglect, Coroner, law enforcement agencies, hospitals) within Los Angeles County that track and report data on child fatalities and a lack of a single entity responsible for cohesively bringing the data together and reporting informative trended data to the Board. Therefore, the department will focus on working with these County agencies and departments to develop a comprehensive approach to tracking and reporting pertinent child fatality data.

II. Single Entity

The Board has moved that the CEO designate a single entity to report on child abuse, neglect, and deaths in order to present meaningful data that can inform critical policy decisions in enhancing child safety and well-being. As mentioned above, there are numerous entities that cross-report child fatality data and there is a need to develop a comprehensive understanding of the various data elements that are currently being tracked in order to establish an efficient and timely reporting protocol of the most informative data. The CEO will convene a work group with the specific purpose of developing a standardized process for compiling and presenting pertinent child fatality data to the Board. This group will also determine which data elements should be tracked in order to provide the Board with data that can inform discussions related to child welfare. Clear parameters for determining whether a child has DCFS history will also be standardized by this workgroup. In addition, the CEO will develop criteria that will facilitate selection of a single entity to be responsible for future reporting. Additional information on the implementation of these efforts can be found in Attachment A.

Each Supervisor
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A status report on the progress in determining criteria for reporting pertinent child fatality data to the Board and establishment of a single entity will be provided.

If you have any questions or need additional information, please let me know, or have your staff contact Antonia Jiménez at (213) 974-7365.

WTF:AJ:DS
SMF:ljp

Attachment

c: Executive Office, Board of Supervisors
Children and Family Services
County Counsel

Child Deaths Board Motion.bm



Department of Children & Family Services

**Motion by Supervisor Mark Ridley–Thomas
and Mayor Michael D. Antonovich**

Reporting Aggregate and Trend Data on Child Deaths

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Data Dictionary

Term	Definition
Family History	<ul style="list-style-type: none"> Sibling of the child had an open case or referral with DCFS at time of child's death or a closed case or referral prior to the child's date of death Parent of the child had an open case or referral with DCFS at time of child's death or a closed case or referral prior to the child's date of death
In-Home	<ul style="list-style-type: none"> Home of Parent
Foster Family Home	<ul style="list-style-type: none"> Home in which 24-hour non-medical care and supervision are provided in a family setting in the licensee's family residence for not more than six foster children
Foster Family Agency Certified Home	<ul style="list-style-type: none"> Home that is certified by a Foster Family Agency, a private agency. When a family is certified by a foster family agency (FFA), a social worker from that agency visits their home on a regular basis. Some foster family agencies are also licensed adoption agencies. In this case a foster family agency social worker may also conduct the adoption home study.
Group Home	<ul style="list-style-type: none"> A facility that provides 24-hour non-medical care and supervision to children A facility that provides services to a specific client group and maintains a structured environment, with such services provided at least in part by staff employed by the licensee
Relative Home	<ul style="list-style-type: none"> Home of a person connected to another by blood or marriage. It includes parent, stepparent, son, daughter, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin or any such person denoted by the prefix "grand" or "great" or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.
Non-Relative Extended Family Member (NREFM) Home	<ul style="list-style-type: none"> Home of any adult caregiver who has established familial or mentoring relationship with the child. The parties may include relatives of the child, teachers, medical professionals, clergy, and neighbors and family friends.
Small Family Home	<ul style="list-style-type: none"> Any residential facility in the licensee's family residence providing 24 hour a day care for six or fewer children with a mental disorder, developmental disability, or physical handicap and who require special care and supervision as a result of such disabilities
Guardian Home	<ul style="list-style-type: none"> Home of guardian who was empowered by a court to be the guardian of a minor
Non-Foster Care	<ul style="list-style-type: none"> Hospitals, medical facilities, and psychiatric facilities that provide medical or mental services on an emergency basis

Board Motion: Statement of Work

Board Motion by Supervisor Mark Ridley-Thomas and Mayor Michael D. Antonovich, voted on October 12 and further amended on November 3, 2010 moved that the Chief Executive Officer (CEO), in consultation with the Department of Children and Family Services (DCFS) and County Counsel, compile vital LA County death statistics for the past ten years including but not limited to:

- **Total number of child deaths with DCFS history;**
- **Age, area of residence, and area of death location of the children;**
- **Cause of death and circumstances;**
- **Abuse or neglect status;**
- **Alleged perpetrator in homicides;**
- **DCFS status and placement at time of death;**
- **Race/ethnicity of the child; and**
- **Indication of whether one or both parents were minors at the time of the child's birth.**

In addition, the Board moved that the CEO report back with a plan to designate a single County entity to be responsible for consistently tracking and compiling LA County data on child abuse, neglect, and deaths.

2000-2010: Working Assumptions & Data Limitations

- Data source is the State's Child Welfare Services/Case Management System (CWS/CMS) as of February 8, 2011
- Child Death Population includes ages 0-17 with DCFS history and 18-21 with an open DCFS case upon date of death
- Child deaths were determined to have DCFS history if they met one of the following criteria:
 - Child had an open case or referral at time of death or a closed case or referral prior to the date of death
 - Sibling of the child had an open case or referral at time of death or a closed case or referral prior to the date of death
 - Parent of the child had a closed case or referral prior to the date of death
- CWS/CMS was not designed to track data on child fatalities, therefore it only tracks a limited amount of information in the case of a child death. For example, CWS/CMS does not track alleged perpetrator in homicides or incident location.
- Some death data fields are not mandatory in CWS/CMS which may result in missing values.
- For comparative purposes, statistics on children receiving services from DCFS and general child population statistics for LA County is provided where applicable.
- In order to provide a more current and comprehensive view of child fatalities with DCFS history for CY 2010, additional validation and analysis was conducted. As such, validated data for CY 2010 is also provided for all data elements available.

2000 – 2010: Data Elements & Data Source

Data Elements Requested	Data Source	Data Available 2000-2010	Available for 2010
1. Total # of child deaths with DCFS history	CWS/CMS	✓	✓
2. Age of Child	CWS/CMS	✓	✓
3. Gender	CWS/CMS	✓	✓
4. Race or Ethnicity	CWS/CMS	✓	✓
5. SB39 Categorization: Death due to Abuse/Neglect ¹	Other Database ¹		✓
6. Area of Residence	CWS/CMS	✓	✓
7. Incident Location	Other Database ¹		✓
8. Captured Trends: Death Circumstances ²		----- Under Development -----	
9. Mode-of-Death per Coroner	Other Database ¹		✓
10. Alleged Perpetrator in Homicides		----- Under Development -----	
11. DCFS Status at Time of Death	CWS/CMS	✓	✓
12. Placement at Time of Death (Open Cases)	CWS/CMS	✓	✓
13. Were parents minors at child's birth	CWS/CMS	✓	✓
14. Were parents minors at child's death	CWS/CMS	✓	✓
15. Did parents have a DCFS referral as a minor	CWS/CMS	✓	✓

¹ Includes information that CWS/CMS is not designed to systematically track

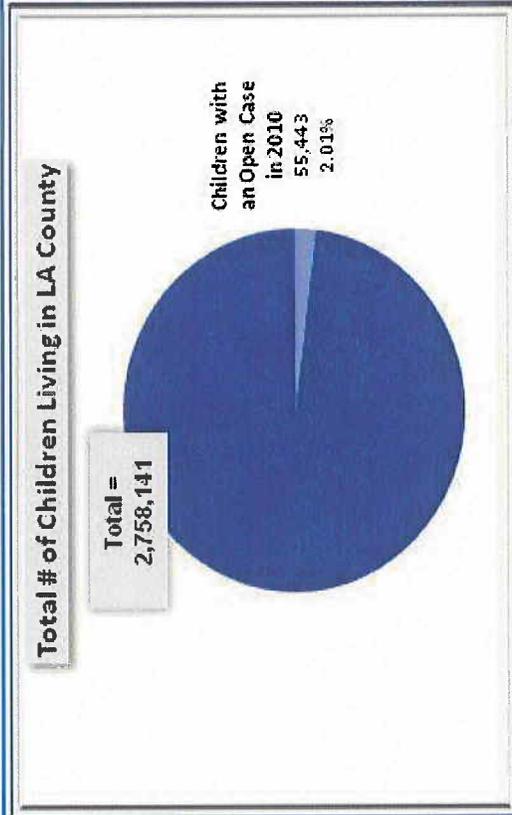
² Not to be confused with Death Circumstances & Death Circumstances. Type in CWS/CMS

**Calendar Years 2000-2010
Aggregate Data &
Calendar Year 2010 Data**

2000-2010 Summary of Data Findings

- Highest number of child deaths by race/ethnicity are Hispanic/Latino (45%) and African American (37%)
- Highest number of child deaths by gender are male (62%)
- Highest number of child deaths by age range are between the ages of 0-1 (37%) and 14-17 (26%)
- DCFS Status prior to or at time of death is as follows:
 - 31% had an open case (24%) or referral (7%)
 - 39% had a closed case or referral (important to note that closed cases or referrals span an entire lifetime – e.g. a closed referral 5 to 7 years ago)
 - 30% did not have DCFS history themselves but had a family member with DCFS history (in addition, the DCFS history could have occurred prior to the child's birth)
- Placement at time of death for the 24% with an open case: 47% In-Home, 37% Out-of-Home, and 16% Other (such as medical facility or psychiatric facility)
- 9% had a minor parent at birth, 2% had a minor parent at death, and 17% had a parent with a DCFS referral as a minor

Contextual Statistics

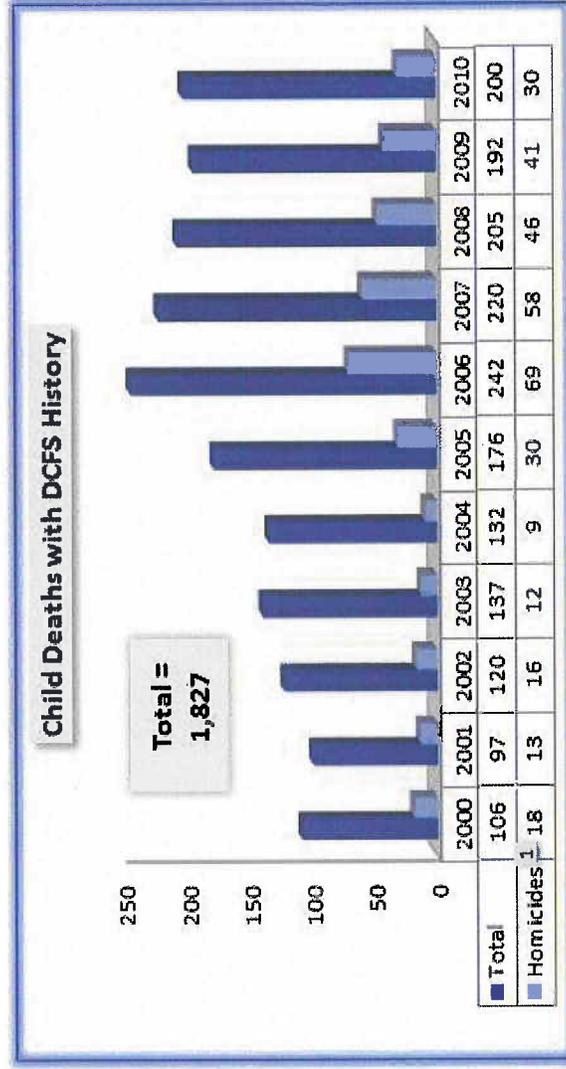


Explanation	Number
The number of children ages 0-17 living in LA County in CY 2009. - Based on the California Department of Finance (census data used to conduct this analysis is not available for CY 2010, therefore we are using CY 2009 data)	2,758,141
The number of children with an open case in CY 2010. This represents approximately 2.01% of the general population of children living in LA County. - Based on CWS/CMS	55,443
The number of open cases as of December 31, 2010. This number represents the approximate number of open cases DCFS is managing at a single point in time. - Based on CWS/CMS	33,795
The number of child fatalities in CY 2010 with DCFS history, which roughly represents 0.32% of the population of children with an open DCFS case in CY 2010. - Based on validated CY 2010 figures and refers to children with ANY DCFS history (including siblings and parents) who died in CY 2010 and is not limited to children who had an open DCFS case in CY 2010	175
The number of fatalities with and without DCFS history with a reasonable suspicion or determination that abuse/neglect led to the child's death in CY 2010. This number includes deaths where a determination was made that abuse/neglect led to the child's death.	60
The number of fatalities with DCFS history with a reasonable suspicion or determination that abuse/neglect led to the child's death in CY 2010, which roughly represents 0.07% of the population of children with an open DCFS case in CY 2010. This number includes deaths where a determination was made that abuse/neglect led to the child's death. - Refers to children with ANY DCFS history (including siblings and parents) who died in CY 2010 and is not limited to children who had an open DCFS case in CY 2010	41

Child Deaths with DCFS History

The following data includes ALL modes of death for child fatalities with DCFS history – including for example, natural deaths, accidental deaths, third-party homicides, and suicides.

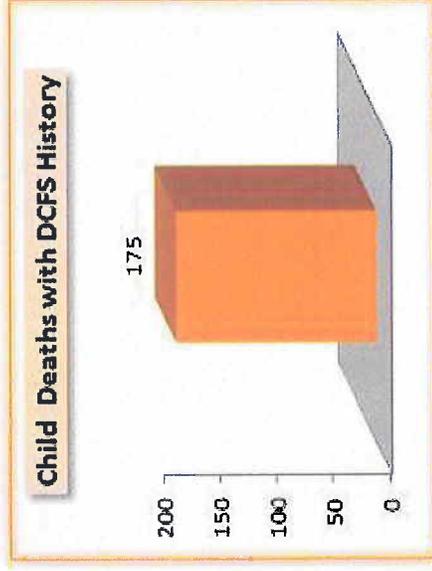
CY 2000-2010 AGGREGATE FATALITY DATA



Note: In June 2005, the Coroner started reporting all child homicides to the DCFS Child Protection Hotline (Hotline). Prior to that, they were only reporting child homicides that were suspected to have been caused by abuse and/or neglect by a parent or caregiver. As a result, the total number of child deaths reported increased.

¹ Based on the Death Circumstances Type field in CWS/CMS which tracks the initial determination as reported to the Hotline; however, a determination may change over time if the Coroner determines otherwise.

CY 2010 FATALITY DATA



Note: Out of the 200 child deaths with DCFS history reported in the aggregate data for CY 2010, 25 children either:

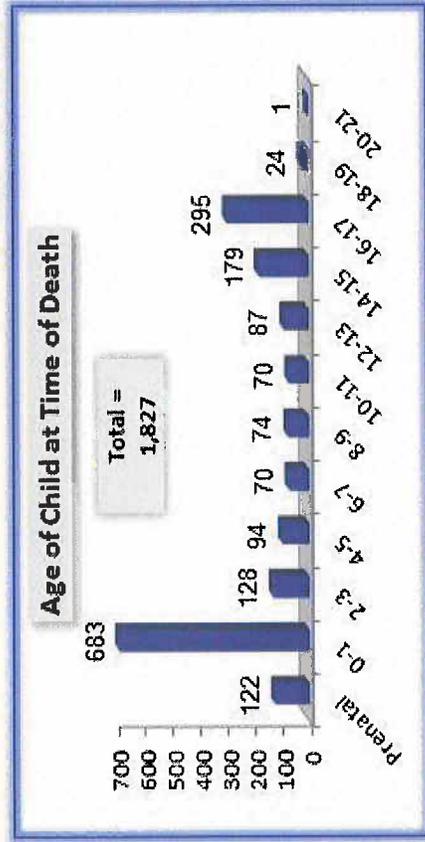
- 1) Upon further review did not have DCFS history or
- 2) Were not an LA County resident at the time of death for children with closed cases or referrals.

All additional analysis on CY 2010-specific data is based on this population of 175 children.

Age of Child at Time of Death

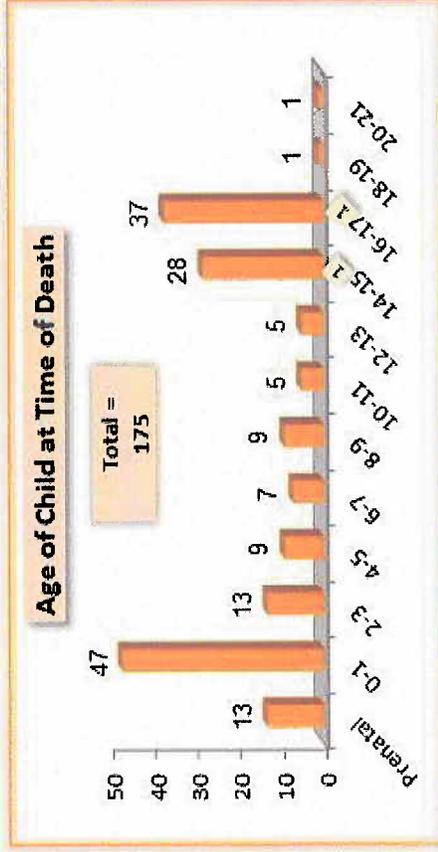
The following data includes ALL modes of death for child fatalities with DCFS history – including for example, natural deaths, accidental deaths, third-party homicides, and suicides.

CY 2000-2010 AGGREGATE FATALITY DATA



Note: CWS/CMS does not have an indicator for prenatal deaths. Therefore, prenatal deaths include children with the same birth date and death date.

CY 2010 FATALITY DATA



Note: CWS/CMS does not have an indicator for prenatal deaths. Therefore, prenatal deaths include children with the same birth date and death date.

Age Group	Number of Fatalities	Percentage
Prenatal	122	7%
Infants (0-1)	683	37%
Children (2-11)	436	24%
Teenagers (12-17)	561	31%
Young Adults (18-21)	25	1%
Total 2000-2010	1,827	100%

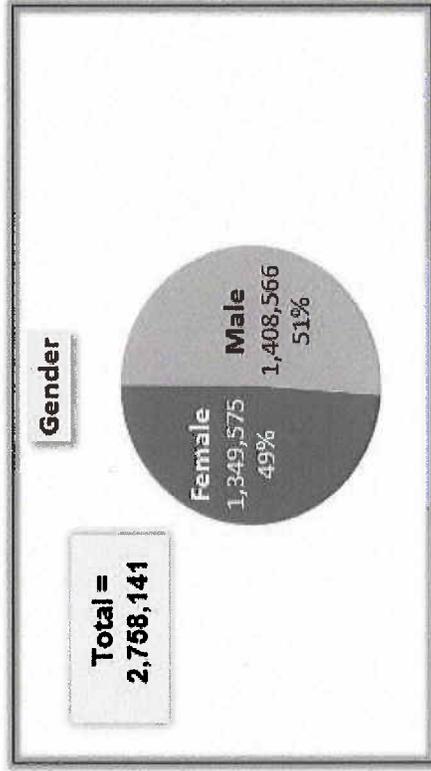
Age Group	Number of Fatalities	Percentage
Prenatal	13	7%
Infants (0-1)	47	27%
Children (2-11)	43	25%
Teenagers (12-17)	70	40%
Young Adults (18-21)	2	1%
Total 2010	175	100%

¹ Of the fatalities between the ages of 14-17: Approximately 80% are male, and 52% appear to be gang-related.

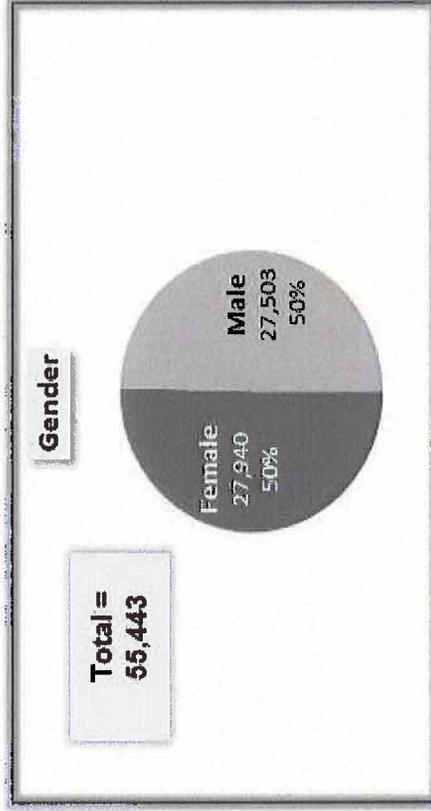
Child Gender

The following CY 2000-2010 aggregate data and CY 2010-specific data includes ALL modes of death for child fatalities with DCFS history – including for example, natural deaths, accidental deaths, third-party homicides, and suicides.

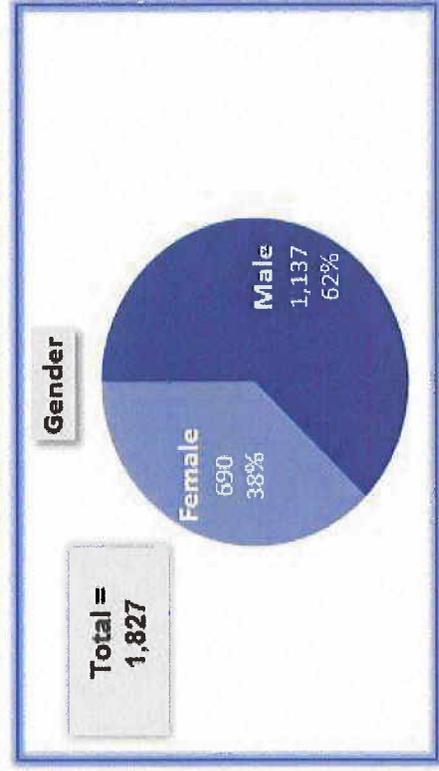
CY 2009 LA County Ages 0-17 Census



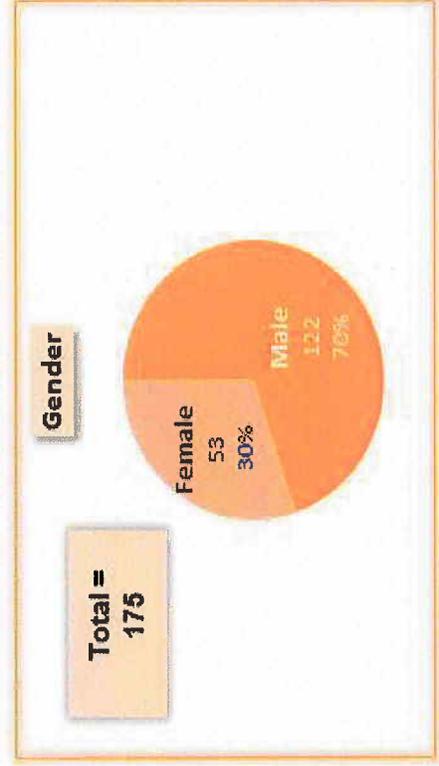
CY 2010 Children With an Open DCFS Case



CY 2000-2010 AGGREGATE FATALITY DATA



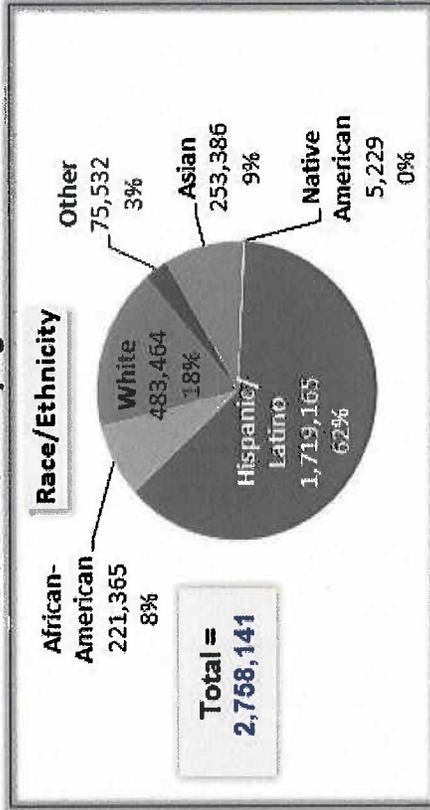
CY 2010 FATALITY DATA



Child Race/Ethnicity

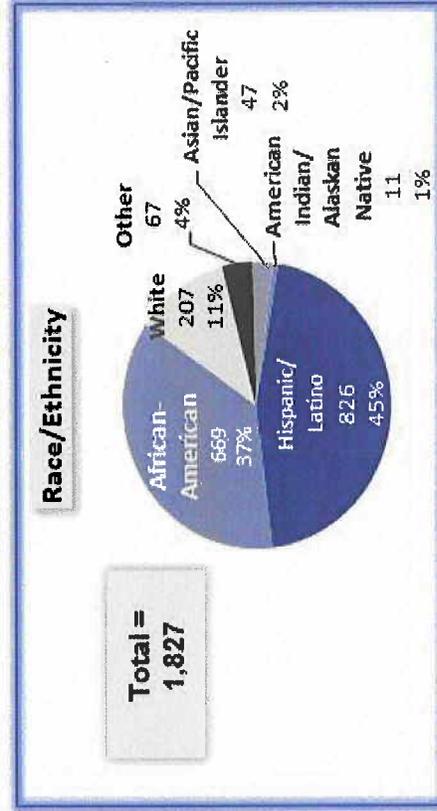
The following CY 2000-2010 aggregate data and CY 2010-specific data includes ALL modes of death for child fatalities with DCFS history – including for example, natural deaths, accidental deaths, third-party homicides, and suicides.

CY 2009 LA County Ages 0-17 Census



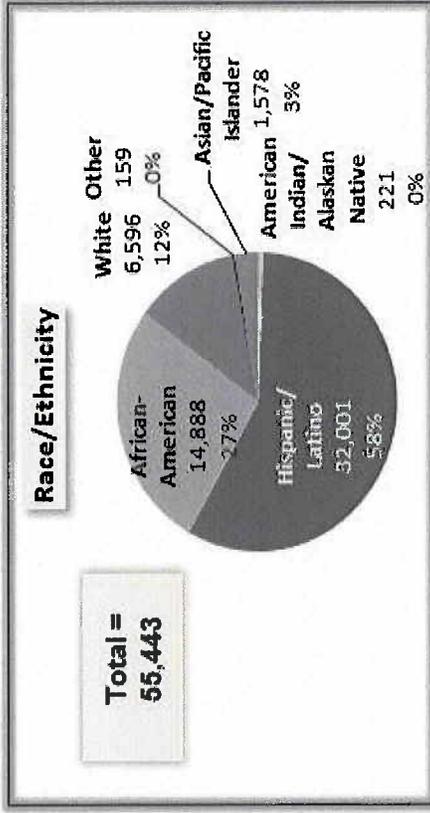
Note: Other includes Declines to State and Mixed Ethnicity

CY 2000-2010 AGGREGATE FATALITY DATA



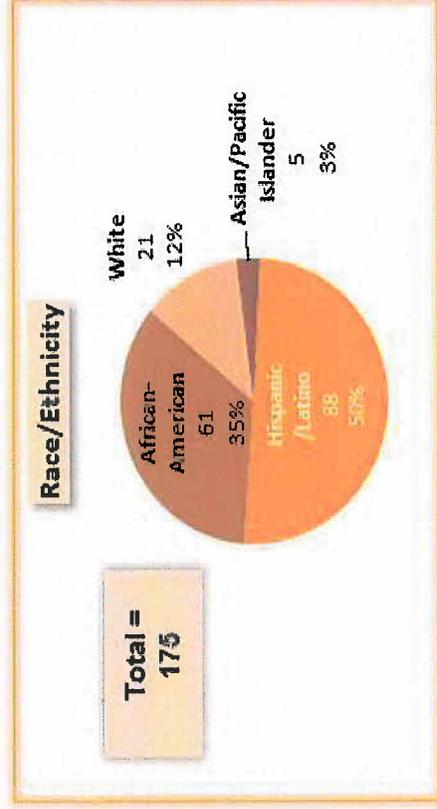
Note: Other includes Declines to State and Mixed Ethnicity

CY 2010 Children With an Open DCFS Case



Note: Other includes Declines to State and Mixed Ethnicity

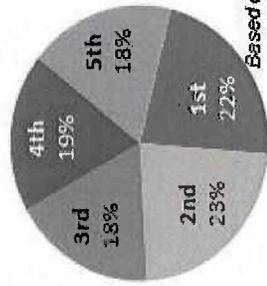
CY 2010 FATALITY DATA



Supervisory District of Residence

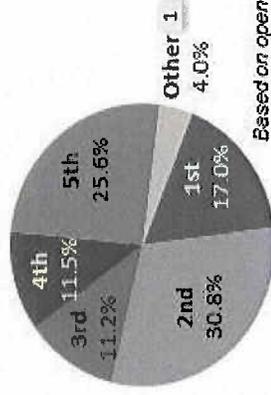
The following data includes ALL modes of death for child fatalities with DCFS history – including for example, natural deaths, accidental deaths, third-party homicides, and suicides.

CY 2009 LA County Ages 0-17 Census



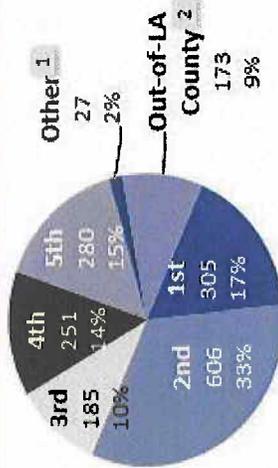
Based on estimates from William R. MacDonald and Associates

CY 2010 Children With an Open DCFS Case



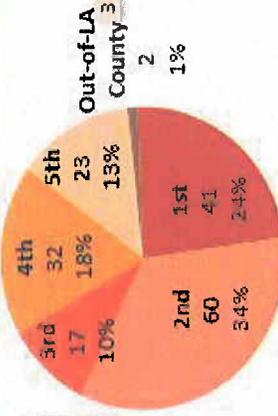
Based on open DCFS cases as of December 31, 2010

CY 2000-2010 AGGREGATE FATALITY DATA



Total = 1,827

CY 2010 FATALITY DATA



Total = 175

Note: Addresses that had missing values in CWS/CMS or could not be geographically coded were placed in a Supervisory District based on the last DCFS office that provided services

1 Indicates addresses that had missing values in CWS/CMS or could not be geographically coded, and were last served by a Countywide DCFS office (e.g. Multi-Agency Response Team (MART))

2 A significant number of children did not reside in LA County but were included in the CY 2000-2010 CWS/CMS aggregate data since they had DCFS history (their own, a sibling, or a parent)

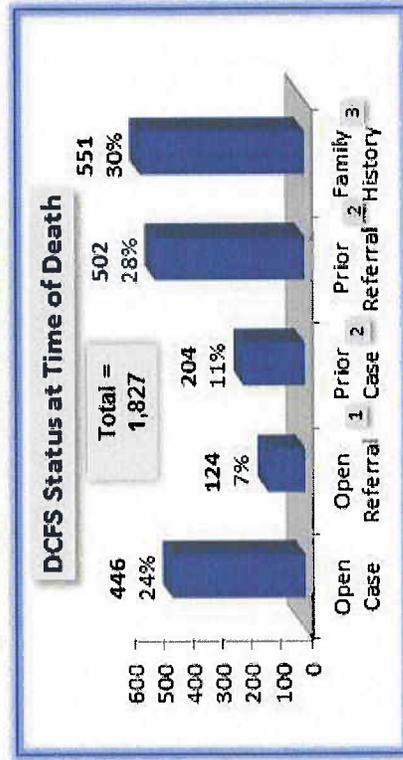
3 Indicates children with DCFS history whose last known residence was outside of LA County

DCFS Status at Time of Death

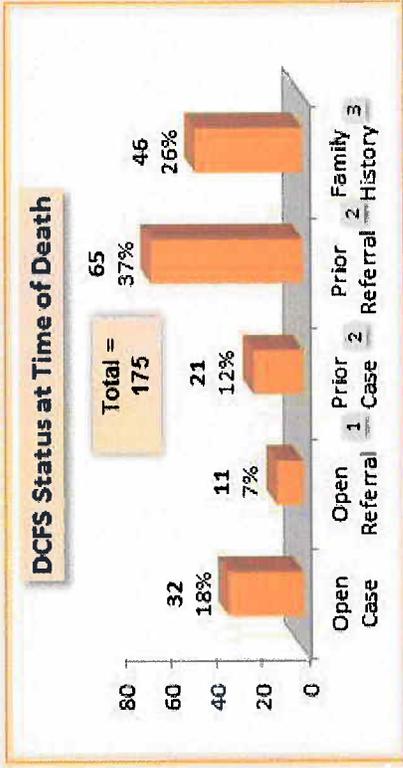
The following data includes ALL modes of death for child fatalities with DCFS history – including for example, natural deaths, accidental deaths, third-party homicides, and suicides.

DCFS status at time of death is prioritized in the following order: 1) Open Case 2) Open Referral 3) Closed Case 4) Closed Referral and 5) Family History. For example, if a child has an open case at time of death, a closed referral two years earlier, and a sibling with an open case then the child is included in the Open Case category.

2000-2010 AGGREGATE FATALITY DATA



2010 FATALITY DATA



¹ Includes all open referrals regardless of the number of days it is open

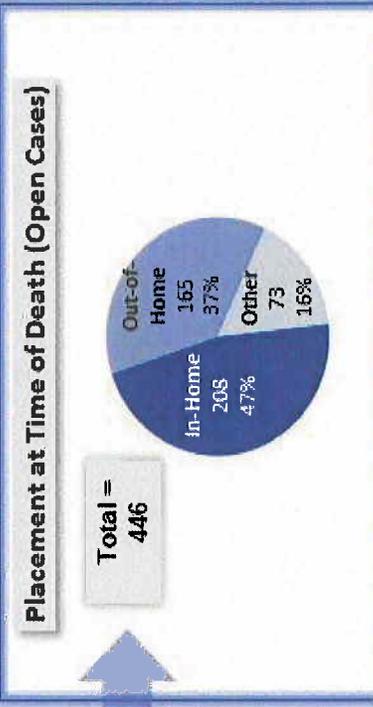
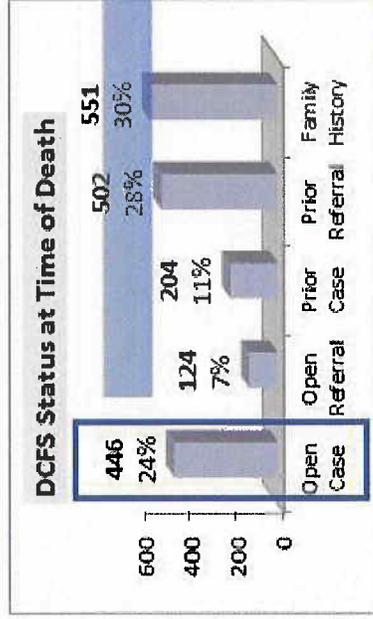
² There is no specified timeframe established for including a child with a closed case or closed referral – e.g., a child with a closed referral seven years ago is still included in this category. The state's practice is to review history going back five years.

³ These children do not have DCFS history themselves, but have a family member who has history with DCFS

Placement at Time of Death (Open Cases)

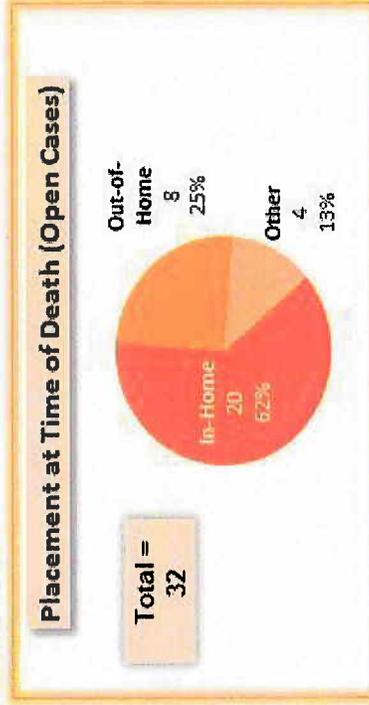
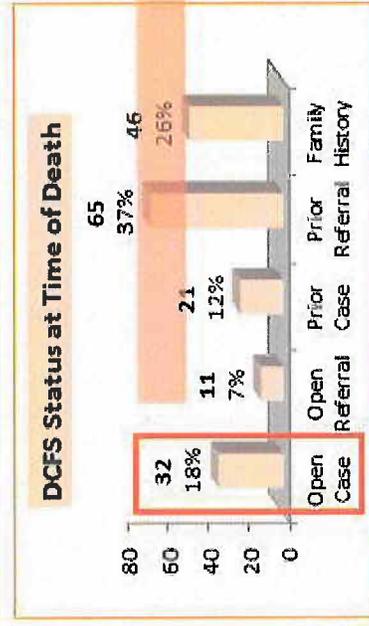
The following data includes ALL modes of death for child fatalities with DCFs history – including for example, natural deaths, accidental deaths, third-party homicides, and suicides.

CY 2000-2010 AGGREGATE FATALITY DATA



Placement	Avg/Year
In-Home	19
Out-of-Home	15
Other	5

CY 2010 FATALITY DATA



In-Home: In-Home

Out-of-Home: Foster Family Home; Foster Family Agency Certified Home; Group Home; Relative/Non-Relative Extended Family Member (NREFM) Home; Small Family Home; Guardian Home; County Shelter/Receiving Home; Court-Specified Home

Other such as: Medical Facility; Psychiatric Facility

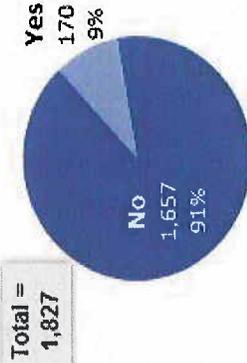
Minor Parent(s)

The following data includes ALL modes of death for child fatalities with DCFS history – including for example, natural deaths, accidental deaths, third-party homicides, and suicides.

CY 2000-2010 AGGREGATE FATALITY DATA

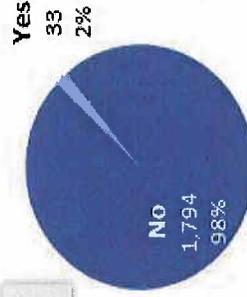
Indicates whether one or both parents were under 18 years of age at the time of the child's birth

Minor Parent(s) at Child's Birth



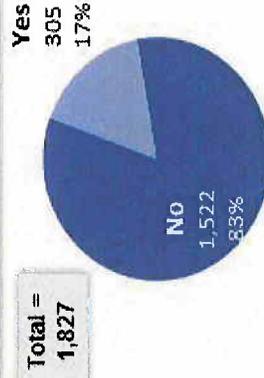
Indicates whether one or both parents were under 18 years of age on the child's date of death

Minor Parent(s) at Child's Death



Indicates whether one or both parents had a DCFS referral when they were under 18 years of age

DCFS Referral on Minor Parent(s)



**Calendar Year 2010
New Data Elements**

New Data Elements – Overview

CWS/CMS was not designed to track child fatality data, and therefore, does not track all of the requested data elements in the Board motion. Additional analysis was conducted to extract the following data elements for CY 2010 ONLY:

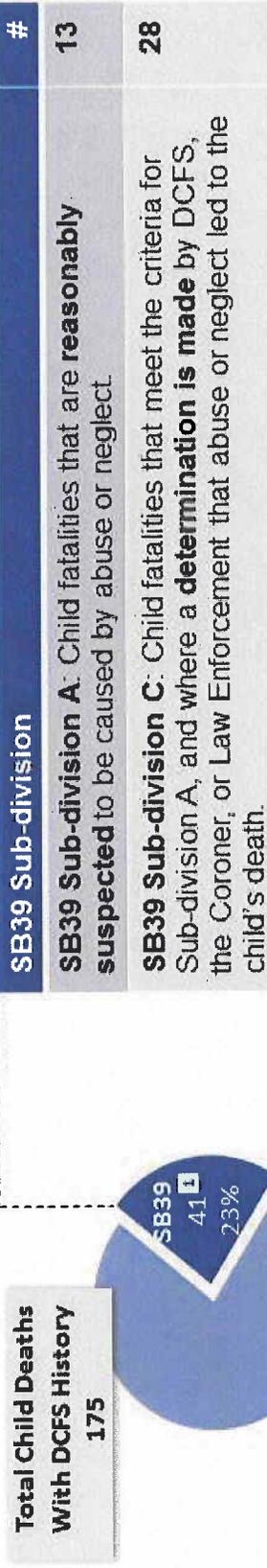
- 1. Abuse or Neglect Status (SB39)**
- 2. Supervisorial District of Incident**
- 3. Final Cause-of-Death per Coroner**
- 4. Final Mode-of-Death per Coroner**

SB39 Abuse or Neglect Status

The following data includes ALL modes of death for child fatalities with DCFS history – including for example, natural deaths, accidental deaths, third-party homicides, and suicides.

Senate Bill 39 (SB39) became effective on January 1, 2008, and applies to child deaths that occurred on that date, or thereafter. SB39 permits a member of the public to request certain information and records regarding child fatalities where there is a reasonable suspicion that the child's death was caused by abuse or neglect, or where a determination is made that abuse or neglect led to a child's death. In August 2010 the Board adopted the recommendations of the Office of Independent Review which called for SB39 determinations to be made in favor of disclosure.

2010 SB39 Status



Data as of February 15, 2011

Note: Out of the 200 child deaths with DCFS history reported in the aggregate data for CY 2010, 25 children either:

- 1) Upon further review did not have DCFS history or
 - 2) Were not an LA County resident at the time of death for children with closed cases or referrals.
- All additional analysis on CY 2010-specific data is based on this population of 175 children.

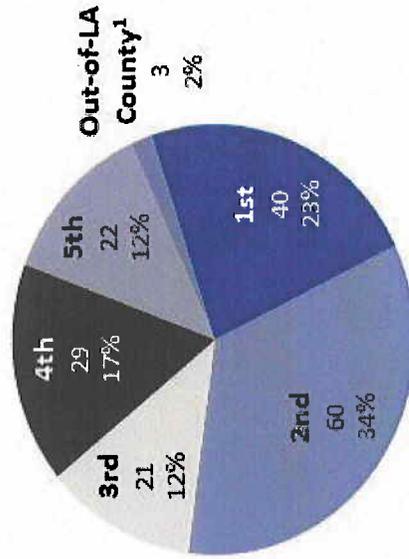
† There were a total of 60 SB39 fatalities for CY 2010 with AND without DCFS history.

Supervisory District of Incident

The following data includes ALL modes of death for child fatalities with DCFS history – including for example, natural deaths, accidental deaths, third-party homicides, and suicides.

2010 Supervisory District of Incident

Total = 175



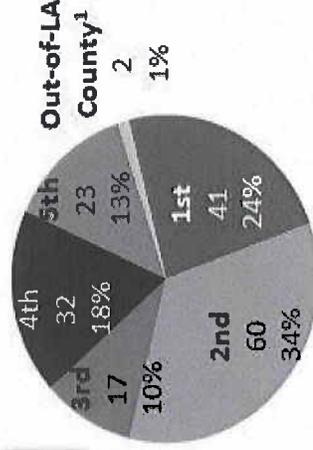
Note: Incident location is determined by the DCFS fatality referral or the Coroner's autopsy report. CWS/CMS does not track incident location.

¹ Indicates a death of a child who was a LA County resident at the time of death but whose incident occurred outside of LA County

For comparative purposes data on Supervisory District of Last Known Residence is again provided here:

2010 Supervisory District of Last Known Residence

Total = 175

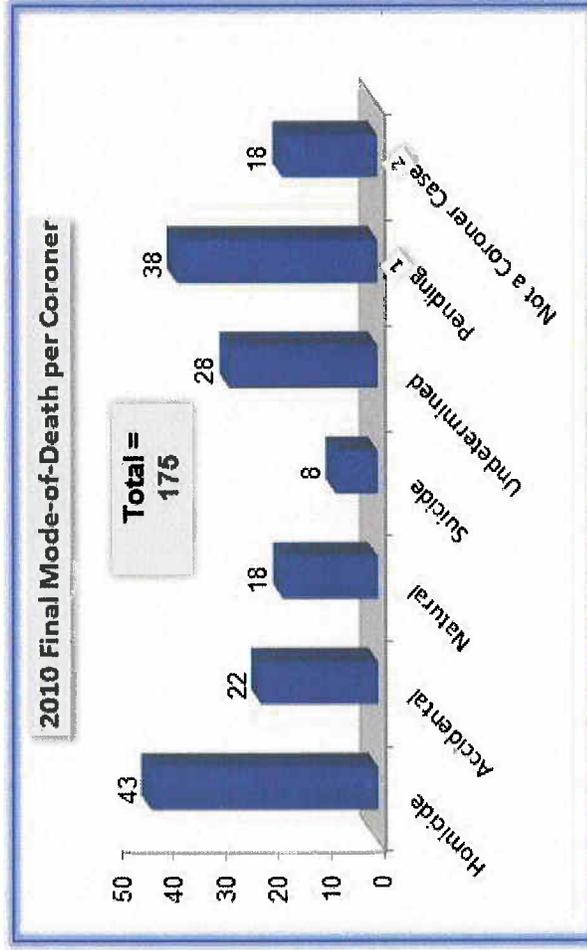


Note: Addresses that had missing values in CWS/CMS or could not be geographically coded were placed in a Supervisory District based on the last DCFS office that provided services

¹ Indicates children with DCFS history whose last known residence is outside of LA County

2010: Final Mode-of-Death per Coroner

The following data includes ALL modes of death for child fatalities with DCFS history – including for example, natural deaths, accidental deaths, third-party homicides, and suicides.

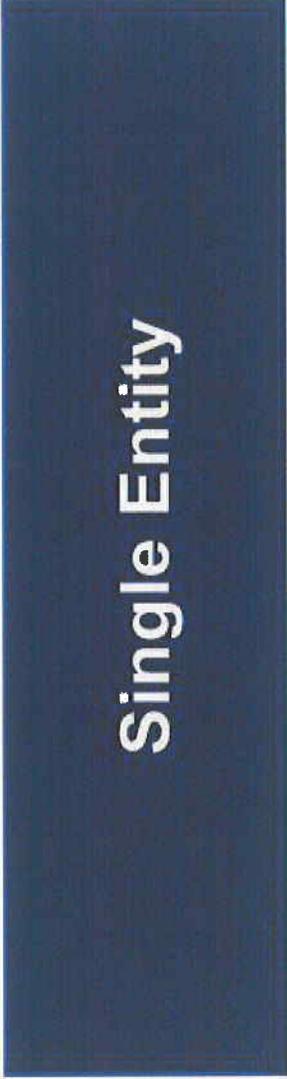


Final Mode-of-Death is determined by the Coroner's autopsy report. The Coroner's standard modes-of-death are:

- Homicide
- Accidental
- Natural
- Suicide
- Undetermined

¹ Indicates that the case is a Coroner's case and is pending an autopsy report

² Indicates that the case was not reported by the Coroner but rather another entity such as a hospital or Law Enforcement. These cases will not have a final mode-of-death from the Coroner.



Single Entity

Single Entity

Board Motion: Develop recommendations for creating a single County entity responsible for consistently tracking and compiling LA County data on child abuse, neglect, and deaths.

BACKGROUND

- There are multiple agencies in LA County that collect and track information on child deaths such as DCFS, Inter-Agency Council on Child Abuse and Neglect (ICAN), Coroner, and various Law Enforcement agencies.
- There is no consistent method for collecting, tracking, and interpreting child death data.
- Data is not always available electronically and there are no standard terms or definitions.
- Each agency collects information in a different method with different reporting frequencies.
- Data is not published timely, making it difficult to use to determine early causes of trends or issues that could help make systemic changes or inform practice.

Entities Role in Child Death Reporting

ICAN

The mission of ICAN is to improve the lives of abused, neglected, and at-risk children through multidisciplinary efforts that support the identification, prevention, and treatment of child abuse and neglect.

- In 1978 the ICAN Multi-Agency Child Death Review Team was formed with representatives from the Coroner, Los Angeles Police Department, Sheriff's, District Attorney's Office, Los Angeles City Attorney's Office, County Counsel, DCFS, Department of Health Services, Office of Education, Department of Mental Health, California Department of Social Services, and representatives from the medical community.
- Annually, the team releases a report on child homicides by a parent, caregiver, or family member, undetermined deaths, accidental deaths, suicides, and third-party homicides for the previous calendar year.
- The child death population includes all Coroner cases ages 17 and under.

Coroner

Existing law requires the Coroner to maintain a "Coroner's Register" for all suspicious and violent deaths and those deaths in which a physician did not see the decedent within 20 days prior to the death.

- Reports all cases ages 17 and under to the Hotline, except for stillborn births in which there are no suspicious circumstances.

Law Enforcement

- Generally reports all child fatalities to the Hotline – frequently relies on the Coroner to report.
- There is no standardized process across the various law enforcement jurisdictions within LA County to report child fatalities to the Hotline.

Hospitals

- Various hospitals have different protocols in place for reporting child fatalities to the Hotline. Most hospitals only report child fatalities to the Hotline if they suspect abuse and/or neglected, while others will report all child deaths.
- It is important to note that DCFS does not have jurisdiction to require private hospitals to report child fatalities to the Hotline

Next Steps

Convene a workgroup led by the CEO, with representatives from DCFS, ICAN, Coroner, and Law Enforcement, charged with:

PROPOSED DRAFT CHARTER

Single Entity is responsible for consistently tracking and compiling LA County data on child abuse, neglect, and deaths in an accurate and timely manner. The Single Entity will be charged with:

- Identifying the system of record for each data element and developing ways to establish standard definitions that can be used to develop timely and accurate child abuse, neglect, and death information.
- Analyzing data to develop regular reports on child abuse, neglect, and deaths. Identifying systemic trends that can be used by DCFS, ICAN, and other entities to support the identification, prevention, and treatment of child abuse and neglect.
- Establishing standard terms and definitions that can be used by all entities.
- Identifying ways to improve data-sharing among the various entities.

The workgroup will present the Board with a proposed project charter, a legal entity responsible for overseeing the Single Entity, and proposed staffing recommendations.